# ANNUAL REPORT
# OF THE
# SELECT JOINT COMMISSION
# ON
# MEDICAID OVERSIGHT

**Indiana Legislative Services Agency**
**200 W. Washington St., Suite 301**
**Indianapolis, Indiana 46204-2789**

**November 2010**

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## 2010

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# Select Joint Commission on Medicaid Oversight

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## Legislative Services Agency Staff

**Kathy Norris, Fiscal Analyst**
**Al Gossard, Fiscal Analyst**
**Casey Kline, Attorney**

**November 2010**

A copy of this report is available on the Internet. Reports, minutes, and notices are organized by committee. This report and other documents for this Commission can be accessed from the General Assembly Homepage at http://www.in.gov/legislative/.

ANNUAL REPORT

**Select Joint Commission on Medicaid Oversight**

## I. STATUTORY AND LEGISLATIVE COUNCIL DIRECTIVES

The Indiana General Assembly enacted legislation (IC 2-5-26) directing the Commission to do the following:

> (1) Determine whether the contractor for the Office under IC 12-15-30 that has responsibility for processing provider claims for payment under the Medicaid program has properly performed the terms of the contractor's contract with the state;
>
> (2) Determine whether a managed care organization (MCO) that has contracted with the Office to provide Medicaid services has properly performed the terms of the managed care organization's contract with the state;
>
> (3) Study and propose legislative and administrative procedures that could help reduce the amount of time needed to process Medicaid claims and eliminate reimbursement backlogs, delays, and errors;
>
> (4) Oversee the implementation of a case-mix reimbursement system developed by the Offices and designed for Indiana Medicaid-certified nursing facilities;
>
> (5) Study and investigate any other matter related to Medicaid; and
>
> (6) Study and investigate all matters related to the implementation of the Children's Health Insurance Program established by IC 12-17-6.

In addition, the Commission was charged by the Legislative Council (LCR 10-01) to study:

> (7) The administration of public assistance including the process of eligibility determinations (HB 1003, HB 1174, and SB 295);
>
> (8) The problems or concerns regarding the administration of public assistance in Indiana based on public testimony and updates concerning changes in the public assistance eligibility process from the Office of the Secretary of the Family and Social Services Administration (FSSA), or the Director of the Division of Family Resources if the Secretary is unavailable, or a contractor for the Office of the Secretary (HB 1003, HB 1174, SB 295); and
>
> (9) Recommendations concerning any changes that the Commission considers necessary concerning the public assistance process in Indiana (HB 1003, HB 1174, SB 295).

## II. INTRODUCTION AND REASONS FOR STUDY

In FY 2010, the Indiana Medicaid program had total expenditures of approximately $6.136 billion dollars. At the end of FY 2010, the program enrolled approximately 1,075,000 Indiana citizens who were eligible to receive services from about 46,700 enrolled providers. Due to the size of this program in the state budget and to the number of the program's recipients and providers, the Select Joint Commission on Medicaid Oversight was established as a permanent commission to provide legislative branch oversight of this state function.

In addition, current Indiana law under P.L. 3-2007, SECTION 1, as amended by P.L. 182-2009(ss), SECTION 486, that establishes the Quality Assessment Fee (QAF) for nursing facilities states that the Select Joint Commission on Medicaid Oversight is to review the implementation of the QAF and that the Office of Medicaid Policy and Planning (OMPP) may not make any change to the reimbursement for nursing facilities unless the Select Joint Commission on Medicaid Oversight recommends the reimbursement change.

The Legislative Council requested the Commission investigate the implementation of the hybrid public assistance eligibility determination process implemented in the spring of 2010, due to concern regarding the administration of public assistance expressed by the introduction of HB 1003, HB 1174, and SB 295, in the 2010 legislative session.

## III. SUMMARY OF WORK PROGRAM

The Commission met three times during the 2010 Interim: August 12, 2010; September 21, 2010; and October 25, 2010. All Commission meetings were held at the State House in Indianapolis.

The first meeting was held August 12, 2010. The Commission was addressed by staff members of Senator Lugar's and Rep. Carson's offices. The Commission received updates concerning the extension of the enhanced Medicaid FMAP stimulus, FSSA activities related to implementation of federal health care reform (ACA), the Disproportionate Share Hospital Program (DSH), Healthy Indiana Plan (HIP), Children's Health Insurance Program (CHIP), Medicaid waivers, and the CHOICE Program. The Commission heard reports concerning the state financial impact of the ACA, state opportunities and options available under the ACA, long-term care and home and community-based services, and proposed Medicaid provider reimbursement reductions for FY 2011. The Commission also took testimony regarding the public assistance eligibility process, the rebalancing of institutional long-term care with home and community-based services, and an administrative decision to reduce FY 2011 funding for CHOICE by 15%. The Commission also received written claims payment updates from Medicaid contractors that process claims for reimbursement (EDS & the MCOs).

The second meeting was held September 21, 2010. The meeting was focused on long-term care issues and the public assistance eligibility determination process. Under the

subject of long-term care, the Commission received updates on nursing facility evaluation and quality measures, quality enhancement activities, Medicaid reimbursement, and complaint investigation and adjudication. They also heard updates on long-term care insurance, including the Partnership Program and the Community Living Assistance Services and Supports (CLASS) Act provisions of the ACA. The Commission heard testimony regarding nursing facility staffing and training, quality measures, reimbursement, and the availability of home and community-based waiver services in Indiana. The Commission also heard a presentation on long-term care provisions within the ACA. In the examination of the public assistance eligibility determination process, the Commission was updated on the progress of the hybrid public assistance eligibility modernization project and heard a student presentation of a paper regarding the privatization of social services.

The third meeting was held October 25, 2010. The meeting was for the purpose of receiving additional program updates and considering and approving legislative recommendations and the Commission's annual report. The Commission heard an update on the Milliman Report, which is the estimate of state cost associated with the federal Accountable Care Act. The Division of Mental Health and Addictions presented transition plans for the state-operated facilities and their residents, as well as program changes within the Medicaid Rehabilitation Option. In the afternoon, the Commission heard a presentation by the Division of Developmental Disability and Rehabilitative Services as well as consumer testimony regarding policy changes made to the Residential Living Allowance program. The Director of the First Steps program reviewed program statistics and actions taken within that program to address a budget deficit. The Commission also received an update on nursing facility staffing and quality of care issues.

## IV. SUMMARY OF TESTIMONY

The Commission heard testimony on several issues over the course of the Interim.

*Medicaid FMAP Federal Stimulus Extension*

FSSA reported that a phased-down extension of the Medicaid stimulus FMAP passed Congress. The stimulus FMAP will be reduced during each of the two quarters of the extension; extended stimulus Medicaid funding will end June 30, 2011. The extension will result in an estimated $200 M in additional federal funding for the Medicaid program.

*Federal Health Care Reform (Affordable Care Act, ACA)*

*Overview of ACA Provisions*

Dr. JoAnn Lamphere of AARP presented an overview of state opportunities available as provisions of the ACA are implemented. Additionally, Mr. Roger Auerbach, a consultant for AARP, reviewed the long-term care provisions and opportunities of the ACA, including the CLASS provisions.

*ACA Implementation Activities*
Ms. Seema Verma reported on FSSA activities undertaken in preparation to implement the provisions of the ACA. She added that interagency task forces had been formed including FSSA and Department of Insurance staff members, as well as staff from the Department of Health and the State Personnel Department when appropriate. A considerable amount of time was taken to review the statute, to determine the activities that required immediate action, and to determine the potential fiscal impact on the state. Ms. Verma described the various task groups assigned and distributed a list of task force activities, which included numerous contacts with the responsible federal agencies and various national associations. Ms. Verma also announced the first meetings on the state implementation of the ACA with interested provider groups. She added that consumers will be included in announcements for future meetings as more specific information is made available by the federal agencies responsible for promulgating the regulations required for implementation of the ACA. Ms. Verma also responded generally to Commission questions regarding the establishment of the required insurance exchanges and the high-risk pool provisions which are responsibilities of the Department of Insurance.

Ms. Robyn Crosson of the Department of Insurance discussed the CLASS Act and explained that little is known about the implementation provisions since these sections of the ACA do not become effective until October 2012. She explained that the CLASS Act involves an employer payroll deduction program. It is not an insurance program, and the Department of Insurance does not have statutory authority to oversee these provisions.

The Commission members asked numerous questions regarding how the ACA would impact or interact with existing state programs and activities.

*ACA Financial Analysis*
Mr. Rob Damler reviewed the Milliman $2.9 B to $3.6 B, ten-year estimate of state costs attributable to the implementation of the ACA. He explained the assumptions used as the basis for the estimates and responded to Commission questions regarding the assumptions. There was considerable discussion concerning the inclusion of $600.1 M to $831.8 M in the cost estimate attributable to a general increase in the physician fee schedule that is not required by the federal ACA. Mr. Damler agreed that while the act requires a two-year primary care fee increase that is to be reimbursed with 100% federal dollars; it does not require a general physician fee increase. However, Milliman included the adjustment to the physician fee schedule because in the actuary's judgement, it will be necessary in order to maintain access to services for the expanded Medicaid population.

Mr. Damler addressed a revision of the Milliman report, dated October 18, 2010, which reflects a change in the treatment of the Medicaid prescription drug rebate provisions and an update of the FFY 2012 federal matching percentage. Mr. Damler explained that after working with the directors of state Medicaid programs, the federal Centers for Medicare and Medicaid Services (CMS) revised how Medicaid prescription drug rebate changes required by the ACA would be captured by CMS. Milliman estimates that the

impact of the change on the Indiana Medicaid program will reduce the cost of the ACA by $298 M. The revised report also includes a savings of $35 M over the life of the estimate attributable to the recently published increased FMAP rate for FFY 2012. These two revisions result in a new state cost range of the ACA of $2.6 B to $3.3 B.

*Disproportionate Share Hospital Program Update*

FSSA staff reported that the DSH eligibility determination for FY 2010/ FY2011 is in process and the 2010 statewide upper payment limit is being calculated. Payments for eligible facilities cannot be calculated until the eligibility determination is completed. It was further reported that the cost methodology used for 2010 will be the same as those used to calculate payments for 2009.

*Healthy Indiana Plan (HIP) Update*

The Commission discussed the status of hospital payments under the HIP as compared to the payments that would have been made in the DSH program. Ms. Verma reported data that have been collected describing characteristics of HIP participants and how they are using the program. The Commission requested updates on the status of the Indiana Check-up Plan Trust Fund and a reconstruction of the original estimates with the actual experience to demonstrate how the actual program enrollment and funding compares to the original estimates.

*Children's Health Insurance Plan (CHIP) Update*

Ms. Pat Casanova reported that the current enrollment in the CHIP is over 70,000 children; exceeding the projections used for the budget. She added that OMPP has requested federal authority to expand the financial eligibility level from 250% FPL to 300% FPL, effective July 1, 2011. The expansion is anticipated to result in the enrollment of an additional 3,500 children.

*First Steps Program Update*

Ms. Dawn Downer, Director of the First Steps Program, reviewed program population and services statistics for FY 2010. She explained the actions taken to eliminate a $15M deficit. The program has implemented a change in prior authorization policy, requiring prior authorization for higher intensity services. Additionally, a proposed rule has been issued that requires providers to be affiliated with networks or supporting agencies. The program does not anticipate providers leaving the program as a result of the proposed rule, but they do anticipate that it will take time for independent single providers to revise their employment.

*Medicaid Mental Health Issues*

Gina Eckart, Director of the Division of Mental Health and Addictions (DMHA), reported on the history and trends of state-operated psychiatric facilities and the Division's transition plans for the state-operated facilities. No facilities will be closed. However, developmentally disabled populations will be moved to appropriate community-based settings, allowing for the closure of some units in state-operated facilities while additional mental illness beds will be opened where most needed. In addition, DMHA is closing the addictions inpatient unit at Richmond State Hospital and preparing to provide addictions treatment as a community-based service throughout the state. Ms.

Eckart responded to several Commission questions regarding the availability of sufficient, appropriate staff for community-based care for residents of state-operated facilities and the extent to which money would be made available to provide community-based care.

Ms. Eckart also provided an update on changes to the Medicaid Rehabilitation Option that were implemented on July 1, 2010.

*Medicaid Waivers and the CHOICE Program*

Ms. Pat Casanova reported on Medicaid waiver slots, commenting that there was substantial growth in the number of total waiver slots available in the last five years. In response to Commission questions, she answered that no clients lost eligibility as a result of federally required changes made to the supported employment follow-along. Ms. Faith Laird reviewed the history of the CHOICE program, volume statistics, and wait list numbers. She added that the Medicaid Aged and Disabled waiver has 3,000 on its waiting list and that 100% state dollars used to provide CHOICE services could be used to leverage federal dollars to provide for more Medicaid waiver slots. Commission questions involved the FY 2010 reversion of CHOICE funds and the imposition of a 15% funding reserve for FY 2011.

Mr. John Cardwell testified that at least one-half of current nursing home residents could be cared for at home resulting in significant savings to the state. He added that 60% of CHOICE recipients were receiving only case management services, an indicator that CHOICE services are being degraded. Mr. Paul Chase testified in opposition to the imposition of a 15% funding reserve on the FY 2011 CHOICE appropriation. Ms. Kristin LaEace directed her comments to the cost differential between caring for patients in a nursing facility as opposed to providing home care. She emphasized that limiting access to home and community-based services forces clients into nursing facilities incurring higher cost for the state.

*Residential Living Allowance Update*

Julia Holloway, Director of the Division of Developmental Disability and Rehabilitative Services (DDARS), updated the Commission on the changes to the Residential Living Allowance (RLA). DDARS revised the definition of household expense that can be met using the RLA, effectively removing food from the budgets since consumers receive federal Food Stamp benefits. The amount of the allocated RLA benefit did not change; more money is now available to assist in paying for housing for about the same number of eligible individuals.

*Medicaid Provider Reimbursement Changes*

Ms. Megan Ornellas referred the Commission to the list of proposed reductions in payments to Medicaid providers in 2011. She reported that OMPP had considered how reductions might influence recipients' access to care and avoided reductions in primary care-related reimbursement. She added that the provider community understood why such reductions are necessary.

*Health Facility Evaluation and Quality Issues*

*Regulation, Quality Measures, and Training Update*

Mr. Terry Whitson reported on the results of licensing and certification surveys performed by the Indiana State Department of Health (ISDH). He compared survey results to national averages and listed healthcare quality issues that are identified by the survey process. He described several initiatives undertaken by the ISDH to improve the quality of care provided, such as the Pressure Ulcer initiative and the Immediate Jeopardy Improvement Project. Mr. Whitson also reported on the outcome of the 2009 ISDH Nursing Home Staffing Study that revealed long-term care staff turnover rates for nurses and certified nurse aides of 74% and 98%, respectively. Mr. Jim Leich presented testimony prepared by the nursing facility associations that cautioned the use of staff turnover ratios as a quality measure if used in isolation. He recommended that a staff retention rate used in conjunction with the turnover rate would result in a more accurate picture of the staffing situation at nursing facilities. Mr. Leich also mentioned that there were discussions with the ISDH concerning the use of the Civil Money Penalty Fund to provide the resources for supervisory training as an opportunity to improve quality by increasing staff retention.

*Medicaid Pay for Performance*

Ms. Faith Laird reviewed the Medicaid case-mix reimbursement system with the Phase II changes in place for nursing facilities and how Phase II provides incentives to improve the quality of care delivered. She also addressed potential quality indicators that are under consideration for inclusion in the Phase III system that is under development. Mr. Jim Leich testified that FSSA has implemented recommendations to improve the quality of care in nursing facilities or is working on the development of the next phase of the recommendations in the Phase III reimbursement system; consequently, no legislation is needed at this time.

*Quality Assessment Fee*

Ms. Laird provided the Commission an update on the Closure and Conversion Fund, which is the residual of QAF dollars remaining after reimbursements for quality measures are made. She reported the balance of the fund is $27.8 M. Ms. Laird reported that if the Quality Assessment Fee was raised to the federal maximum allowed of 5.5% of Medicaid revenue, it would generate approximately $46.6 M in additional state dollars.

*Complaint Investigation and Adjudication*

Members of the Attorney General's Office described the complaint investigation process, the sources of referrals, and the disposition of the complaints. Attorney General Greg Zoeller addressed the Commission and outlined four recommendations for improvements that would improve patient protections. The recommendations were:

(1) Enact legislation requiring applicants for professional licensure or certification to undergo a criminal background check. In addition, county prosecutors should also be required to notify the Professional Licensing Agency if a licensee is convicted of a crime.

(2) ISDH and the Attorney General should continue to refine and enhance protocols concerning the reporting of discipline issues to the responsible

licensing entities.
(3) Provide whistleblower protection to nursing home administrators and staff who make reports of misconduct.
(4) Require nursing facilities to report any termination of licensed individuals to their respective licensing board. Additionally, insurance companies should be required to report any settlement or judgement involving negligence in nursing home care.

*Long-Term Care Insurance*

Ms. Robyn Crosson provided staff with copies of long-term care insurance promotional materials. (This material is included in the attachments to the minutes for the meeting of September 21, 2010.) She explained what the policies cover and that the Department of Insurance (DoL) promotes the product but does not sell insurance policies. She reviewed the activities the DoL performs in promoting the Partnership policies and reviewed statistics of qualifying Partnership policies sold and in force. There is no information available on the total number of long-term care policies issued in the state.

*Public Assistance Eligibility Determination Process*

*Hybrid Process*

Secretary Murphy reviewed public assistance application statistics with the Commission, demonstrating increases in the number of public assistance enrollees, a decrease in the backlog of Medicaid disability applications, and improvement in key metrics in regions that have been converted to the hybrid eligibility determination process. Commission members commented on the lack of complaints within the regions that have implemented the hybrid process. In response to a question regarding why the hybrid system could not be rolled out faster since it appeared to be a better service delivery model, Secretary Murphy explained that the federal Food and Nutrition Services Agency required two months of operational data in each region before the state is approved to expand the model to another region.

The Commission also received testimony indicating that privatizing social work is not efficacious and that the eligibility system is still difficult for consumers to navigate.

## V. COMMITTEE FINDINGS AND RECOMMENDATIONS

The Commission made the following recommendations:

*PD 3351 - Indiana Check-up Plan*

Upon proper motion, the Commission voted 8 to 0 to recommend PD 3351, which specifies that interest accruing from the investment of funds in the Indiana Check-up Plan Trust Fund must be deposited in the fund and requires the Office of Medicaid Policy and Planning to post certain information on the Indiana Check-up Plan's website before the office may place individuals on a waiting list or stop enrollments in the plan.

Annual Report

Upon proper motion, the Commission voted 7 to 0 to approve the annual report, understanding that staff would include information provided at the October 25, 2010, Commission meeting.

# W I T N E S S  L I S T

Mr. Roger Auerback, representing AARP
Mr. John Cardwell, Generations Project
Ms. Pat Casanova, Director, Office of Medicaid Policy and Planning, FSSA
Mr. Paul Chase, Associate State Director for Public Policy, AARP IN
Ms. Robyn Crosson, Chief Deputy Commissioner, IN Department of Insurance
Mr. Rob Damler, Milliman Inc.
Mr. Steven Dick
Ms. Dawn Downer, Director, First Steps Program, DDARS, FSSA
Ms. Gina Eckart, Director, DMHA, FSSA
Ms. Kristine Ellerbruch, Office of Medicaid Policy and Planning, FSSA
Mr. Raymond Fletcher
Mr. Bill Gibson of Senator Richard Lugar's Office
Ms. Robyn Grant, United Senior Action
Ms. Nancy Griffin, Generations Project
Ms. Katie Harris, Student, Valparaiso University
Mr. Bob Holda
Ms. Julia Holloway, Director, DDARS, FSSA
Ms. Sarah Jagger, Policy Director, Office of Medicaid Policy and Planning, FSSA
Ms. Tia Kolasa, Student, Valparaiso University
Ms. Kristin LaEace, CEO, IN Association of Area Agencies on Aging
Ms. Faith Laird, Director, Division on Aging, FSSA
Ms. JoAnn Lamphere, DrPH, Director, State Government Relations & Advocacy, AARP
Mr. Jim Leich, President /CEO. IN Association of Homes and Services for the Aging
Mr. Vince McGowen, Chairman, Hoosier Owners and Providers for the Elderly
Mr. Dave Miller, Legislative Liaison, Attorney General's Office
Ms. Ann Murphy, Secretary, FSSA
Mr. Justin Ohlemiller of Congressman Andre Carson's Office
Ms. Megan Ornellas, Chief Financial Officer, FSSA
Mr. Allen Pope, Director, Medicaid Fraud Division, Attorney General's Office
Mr. Scott Tittle, President, Indiana Health Care Association
Ms. Teresa Torres, Director, Everybody Counts
Ms. Rebecca Vaughn, Program Director, IN Long-Term Care Partnership
Ms. Seema Verma, FSSA
Mr. Terry Whitson, Assistant Commissioner on Health Care Regulatory Services, ISDH
Mr. Greg Zoeller, Attorney General